Complete Summary

GUIDELINE TITLE

Guidelines for the management of alopecia areata.

BIBLIOGRAPHIC SOURCE(S)

MacDonald Hull SP, Wood ML, Hutchinson PE, Sladden M, Messenger AG. Guidelines for the management of alopecia areata. Br J Dermatol 2003 Oct;149(4):692-9. [59 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Alopecia areata

GUIDELINE CATEGORY

Diagnosis
Management
Treatment

CLINICAL SPECIALTY

Dermatology
Family Practice
Internal Medicine

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To provide evidence based guidance for the management of patients with alopecia areata

TARGET POPULATION

Patients with alopecia areata

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis

1. Differential diagnosis
2. Appropriate tests when diagnosis is in doubt: fungal culture, skin biopsy, serology for lupus erythematosus, serology for syphilis

Treatment/Management

1. No treatment
2. Intralesional corticosteroids (e.g., hydrocortisone acetate, triamcinolone acetonide)
3. Contact immunotherapy (contact allergen normally used is 2,3-diphenylcyclopropenone [DPCP])
4. Counselling
5. Use of wigs

Interventions Considered But Not Recommended

Topical corticosteroids, systemic corticosteroids, phototherapy, photochemotherapy, minoxidil, dithranol, ciclosporin, oral zinc, isoprinosine, and aromatherapy.

MAJOR OUTCOMES CONSIDERED

- Hair regrowth
- Remission rate
- Disease recurrence
- Side effects of treatments

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

I: Evidence obtained from at least one properly designed, randomized controlled trial

II-I: Evidence obtained from well designed controlled trials without randomization

II-ii: Evidence obtained from well designed cohort or case-control analytic studies, preferably from more than one centre or research group

II-iii: Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments (such as the introduction of penicillin treatment in the 1940s) could also be regarded as this type of evidence.

III: Opinions of respected authorities based on clinical experience, descriptive studies, or reports of expert committees

IV: Evidence inadequate owing to problems of methodology (e.g., sample size, or length or comprehensiveness of follow-up or conflicts of evidence)

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Recommendation Grades

A. There is good evidence to support the use of the procedure.
B. There is fair evidence to support the use of the procedure.
C. There is poor evidence to support the use of the procedure.
D. There is fair evidence to support the rejection of the use of the procedure.
E. There is good evidence to support the rejection of the use of the procedure.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Draft guidelines are edited by the Therapy Guidelines and Audit Sub-committee (TGA) and subsequently returned to the task force for revision. The approved draft version is published in the quarterly British Association of Dermatologists (BAD) newsletter, and all BAD members are given the opportunity to respond, positively or negatively, but hopefully helpfully, within three months of publication. Finalised guidelines are approved by the TGA and the Executive Committee of the BAD and finally published in the British Journal of Dermatology.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Levels of evidence (I-IV) and grading of recommendations (A-E) are defined at the end of the "Major Recommendations" field.

Diagnosis

The diagnosis of alopecia areata is usually straightforward although the following may cause diagnostic difficulties:

- Trichotillomania: this condition probably causes most confusion and it is possible that it coexists with alopecia areata in some cases. The incomplete nature of the hair loss in trichotillomania and the fact that the broken hairs are firmly anchored in the scalp (i.e. they remain in the growing phase, anagen, unlike exclamation mark hairs) are distinguishing features
- Tinea capitis: the scalp is inflamed in tinea capitis and there is often scaling but the signs may be subtle.
- Early scarring alopecia
- Telogen effluvium
- Anagen effluvium (drug-induced) may mimic diffuse alopecia areata
- Systemic lupus erythematosus
- Secondary syphilis

Occasionally, alopecia areata presents as diffuse hair loss which can be difficult to diagnose. The clinical course often reveals the true diagnosis but a biopsy may be necessary in some cases.

Investigations

Investigations are unnecessary in most cases of alopecia areata. When the diagnosis is in doubt appropriate tests may include:

- Fungal culture
- Skin biopsy
- Serology for lupus erythematosus
- Serology for syphilis

The increased frequency of autoimmune disease in patients with alopecia areata is probably insufficient to justify routine screening.

Management

An overriding consideration in the management of alopecia areata is that, although the disease may have a serious psychological effect, it has no direct impact on general health that justifies the use of hazardous treatments, particularly of unproven efficacy. In addition, many patients, although by no means all, experience spontaneous regrowth of hair.

Counselling

An explanation of alopecia areata, including discussion of the nature and course of the disease and the available treatments, is essential. Some patients are profoundly upset by their alopecia and may require psychological support. Contact with other sufferers and patient support groups may help patients adjust to their disability. The decision to treat alopecia areata actively should not be taken lightly. Treatment can be uncomfortable for the patient, time consuming and potentially toxic. It may also alter the patient's attitude to their hair loss. Some patients find it difficult to cope with relapse following or during initially successful treatment and they should be forewarned of this possibility. These considerations are particularly important in children where the social disruption and focusing of the child's attention on their hair loss, which may result from active treatment,

have to be weighed carefully against the potential benefits. On the other hand, some patients are appreciative that something has been tried, even if it does not work.

Summary of Treatment Recommendations

Alopecia areata is difficult to treat and few treatments have been assessed in randomized controlled trials. The tendency to spontaneous remission and the lack of adverse effects on general health are important considerations in management, and not treating is the best option in many cases. On the other hand, alopecia areata may cause considerable psychological and social disability and in some cases, particularly those seen in secondary care, it may be a chronic and persistent disease causing extensive or universal hair loss. In those cases where treatment is appropriate there is reasonable evidence to support the following:

- Limited patchy hair loss: Intralesional corticosteroid. (B III)

  Intralesional corticosteroids stimulate hair regrowth at the site of injection. The effect is temporary, lasting a few months, and it is unknown whether the long-term outcome is influenced.

- Extensive patchy hair loss: Contact immunotherapy (B II-ii)
- Alopecia totalis/universalis (AT/AU): - Contact immunotherapy (B II-ii).
- Topical steroids used under occlusion (17.8% long-term response) (B II-i)

  Contact immunotherapy is the best-documented treatment in severe alopecia areata but it is not widely available, involves multiple visits to hospital over several months, and stimulates cosmetically worthwhile hair regrowth in <50% of patients with extensive patchy hair loss. It is the only treatment likely to be effective in AT/AU although the response rate in such patients is even lower. It may cause troublesome temporary local inflammation but serious side effects are rare. 2,3-diphenylcyclopropenone [DPCP] is susceptible to degradation by ultraviolet light and needs to be protected from light during storage and by covering the skin after application

Potent topical corticosteroids and, to a lesser extent, dithranol and minoxidil lotion, are widely prescribed by dermatologists for limited patchy alopecia areata, and are safe, but there is no convincing evidence that they are effective.

Continuous or pulsed systemic corticosteroids and psoralen plus ultraviolet A (PUVA) have also been used to treat alopecia areata. However, in view of the potentially serious side effects and inadequate evidence of efficacy, none can be recommended at this time.

Children may be treated in a similar fashion to adults. However, intralesional corticosteroids are often poorly tolerated and many clinicians are reluctant to use aggressive treatments such as contact immunotherapy in children.

Definitions:

Levels of Evidence

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Recommendation Grades

A. There is good evidence to support the use of the procedure.
B. There is fair evidence to support the use of the procedure.
C. There is poor evidence to support the use of the procedure.
D. There is fair evidence to support the rejection of the use of the procedure.
E. There is good evidence to support the rejection of the use of the procedure

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each treatment recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Consistent quality of care for patients with alopecia areata

POTENTIAL HARMS

- Skin atrophy at the site of injection is a consistent side effect of intralesional corticosteroid therapy, particularly if triamcinolone is used.

- There is a risk of cataract and raised intraocular pressure if intralesional corticosteroids are used close to the eye.
- Side effects of contact immunotherapy include development of occipital and/or cervical lymphadenopathy (usually temporary but may persist throughout the treatment period), severe dermatitis, urticaria, and vitiligo. Cosmetically disabling pigmentary complications, both hyper- and hypopigmentation (including vitiligo), may occur if contact immunotherapy is used in patients with racially pigmented skin.

CONTRAINDICATIONS

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There are no data on the safety of contact immunotherapy during pregnancy and it should not be used in pregnant women or in women intending to be come pregnant.

QUALIFYING STATEMENTS

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- Contact immunotherapy is an unlicensed treatment that uses a nonpharmaceutical grade agent. Patients should be fully informed about the nature of the treatment; they should be given an information sheet and give signed consent. Great care must be taken to avoid contact with the allergen by handlers, including pharmacy, medical and nursing staff, and other members of the patient's family. Those applying the allergen should wear gloves and aprons. There are no data on the safety of contact immunotherapy during pregnancy and it should not be used in pregnant women or in women intending to become pregnant. Owing to these concerns about sensitization and the extent of the measures required to prevent this, and also because of the possible risks in pregnancy, availability of contact immunotherapy is limited and many departments are unwilling to provide this treatment.
- These guidelines have been prepared for dermatologists on behalf of the British Association of Dermatologists and reflect the best data available at the time the report was prepared. Caution should be exercised in interpreting the data; the results of future studies may require alteration of the conclusions or recommendations in this report. It may be necessary or even desirable to depart from the guidelines in the interests of patients and special circumstances. Just as adherence to guidelines may not constitute a defence against a claim of negligence, so deviation from them should not necessarily be deemed negligent.
- It is important that these guidelines are used appropriately in that they can only assist the practitioner and cannot be used to mandate, authorise, or outlaw treatment options. Of course it is the responsibility of the practising clinician to interpret the application of guidelines, taking into account local circumstances.
- Guidelines are inherently a fluid, dynamic process and will be updated on the British Association of Dermatologists (BAD) Web site on a regular basis.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

MacDonald Hull SP, Wood ML, Hutchinson PE, Sladden M, Messenger AG. Guidelines for the management of alopecia areata. Br J Dermatol 2003 Oct;149(4):692-9. [59 references] PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2003 Oct

GUIDELINE DEVELOPER(S)

British Association of Dermatologists

SOURCE(S) OF FUNDING

British Association of Dermatologists

GUIDELINE COMMITTEE

British Association of Dermatologists Therapy Guidelines and Audit Subcommittee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

None of the authors has a financial or commercial interest in any of the treatments discussed. A.G.M. occasionally acts as a consultant to pharmaceutical companies who manufacture and market products for the treatment of hair loss disorders.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the British Association of Dermatologists Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- Griffiths CE. The British Association of Dermatologists guidelines for the management of skin disease Br J Dermatol. 1999 Sep;141(3):396-7.

Electronic copies: Available in Portable Document Format (PDF) from the British Association of Dermatologists Web site.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on April 20, 2005. The information was verified by the guideline developer on June 27, 2005.

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